MinnesotaHospice
THE GOLD STANDARD of Care

Patient: _____ DOB: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____(name of patient/personal representative) hereby authorize the release of personal health information to Minnesota Hospice regarding the following patient:

Patient Name & Address:	Date of Birth: Patient's Phone:
Disclosing Agency Name, Address, Phone & Fax:	Information to be provided to: **Minnesota Hospice** **17645 Juniper Path, Suite 155** **Lakeville, MN 55044** **P 952-898-1022** **F 952-898-4006**

The purpose or need for this disclosure is Hospice. Please include 6 months of information for the items checked below.

☑ Discharge summary
☑ Lab results
☑ History and physical exam
☑ Consultation reports
☑ HIV/AIDS test results and treatment if applicable
☑ Alcohol/drug abuse treatment/referral if applicable
☑ Progress notes
☑ Photographs, videotapes, or other images
☑ Mental health - other than psychotherapy notes
☑ X-Ray reports
☑ Summary of treatment
☑ Other_____

I understand that I may revoke this authorization in writing submitted at any time to the company, except to the extent that action has already been taken on this authorization or this authorization was obtained as a condition of obtaining insurance coverage or a policy in which case other law may provide the insurer with the right to contest a claim under the policy.

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date is stated here. *Specify new date:*_____

I understand that the company will not condition treatment or eligibility for care on my providing this authorization except if such care is research related.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] and the Privacy Act of 1974 [5 USC 552a].

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

If the purpose is for marketing, will the company receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ Yes ☑ No

Patient/Authorized Representative Signature _____ Date _____

Minnesota Hospice Representative Signature _____ Date _____